

# South Carolina Department of Disabilities and Special Needs

## PDD Temporary State Funded Program Notice of Disenrollment

Date Form Completed: \_\_\_\_\_

Participant's Name: \_\_\_\_\_

Medicaid #: \_\_\_\_\_

SSN#: \_\_\_\_\_

The participant named above is no longer eligible to receive services funded through the PDD State Funded Program for the reason noted below:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Death   | <input type="checkbox"/> Admitted to an ICF/MR                 | <input type="checkbox"/> No longer meets ICF/MR Level of Care |
| <input type="checkbox"/> Other _____   | <input type="checkbox"/> Voluntary withdrawal                  | <input type="checkbox"/> Participant moved out of state       |
| <input type="checkbox"/> No services received in 30 days   | <input type="checkbox"/> No services received since enrollment |   |
| <input type="checkbox"/> Placement in Nursing Facility/Hospital has exceeded 30 consecutive calendar days and the participant has no expectation to return to the PDD Waiver |  |   |

- ☐ Participant has not received the needed service for 30 consecutive calendar days due to provider non-availability [The individual will be disenrolled, but will remain pending for 90 days; therefore, retaining the waiver slot. If a provider has not been located within 90 days, the individual will be removed from pending status and the slot will be revoked. If a provider is secured within 90 calendar days, the participant must be re-enrolled: (Freedom of Choice must be completed and a new initial Level of Care requested).

### EFFECTIVE DATE OF DISENROLLMENT: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

The effective date is 10 calendar days from the date the form is completed with the exception of death, loss of Medicaid, or admission to an ICF/MR or Nursing Facility or the participant moves out-of-state. This allows the legal guardian notice prior to disenrollment/loss of services and the right to appeal without services being terminated.

**As a result of this disenrollment, service(s) currently being provided will be terminated with this effective date. Contact your Case Manager about these services or any questions that you may have.**

If form completed more than 2 days after the termination date, provide reason for delay: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Case Manager: \_\_\_\_\_

DSN Board/Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Original: Legal Guardian

Copy: Waiver Enrollment Coordinator, and File

SAMPLE